



Medical Examiner Department
Public Interment Program (PIP)
FAX: 305-545-2409

AUTHORIZATION FOR CREMATION AND DISPOSITION

DATE: _____
Month/Day/Year

NAME OF DECEASED

PIP #:

I/We, the undersigned, hereby request, authorize and direct Miami-Dade County to cremate the above named remains in accordance with, and subject to the Florida Statutes governing Crematories/Direct Disposers.

I/We understand that Florida Law authorizes the disposal of unclaimed cremains after 120 days from the date of cremation.

I/We agree to indemnify, release and hold Miami-Dade County, its agents and employees harmless from any and all loss, damages, liability or causes of action (including attorney's fees and expenses of litigation) in connection with the cremation and disposition of the cremated remains of the deceased, as authorized below:

SIGNATURE OF PERSONS (S) AUTHORIZING CREMATION AND DISPOSITION

Print Name

Relationship to Deceased

Signature

ADDRESS: _____ Tel. No. _____

WITNESS: _____

Print Name

Signature

ADDRESS: _____ Tel. No. _____

Cremains Disposition: Authorized person will claim ashes Scatter as Appropriate